

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06492

CERTIFICATE OF DEATH

06479

1. PLACE OF DEATH a. COUNTY <u>CARROLL CO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER RD #4</u>	
c. LENGTH OF STAY IN 1b <u>10 DAYS</u>		d. STREET ADDRESS <u>OLD MANCHESTER ROAD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL CO. GENERAL HOSPT</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GOLDIE IRENE ANASTASIO</u> First Middle Last		4. DATE OF DEATH <u>5</u> Month <u>5</u> Day <u>19</u> Year <u>67</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>AUG-21-1901</u> 65 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE-WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>CARROLL CO. MD.</u>
13. FATHER'S NAME <u>DAVID WADDELL</u>		14. MOTHER'S MAIDEN NAME <u>NETTIE NAILL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>159-22-1088D</u>	17. INFORMANT <u>MRS. HILDA LOTZ</u> Address <u>MD. WESTMINSTER RD #4</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> DUE TO (b) <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>331X</u> DUE TO (c) <u>331X</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4/25</u> , 19 <u>67</u> , to <u>5/5</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/5</u> , 19 <u>67</u> , and that death occurred at <u>10:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Thomas J. K... Jr</u>		22b. DATE SIGNED <u>5/5/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>5/9/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE MD.</u>
24. FUNERAL DIRECTOR <u>J. S. Myers Jr.</u>		25a. REC'D BY REGISTRAR <u>MAY 8 1967</u>	25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>



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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06493

CERTIFICATE OF DEATH

06480

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Westminster 06-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll County General Hospital</u>				d. STREET ADDRESS <u>R. D. 5</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HOWARD L. BAIR, SR.</u>				4. DATE OF DEATH Month Day Year <u>May 30, 1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Oct. 11, 1884</u>		9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nathan Bair</u>				14. MOTHER'S MAIDEN NAME <u>Lucretia Green</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-12-2292A</u>		17. INFORMANT Address <u>Mrs. Mamie Bair Same As #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>154X</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Metastatic adenocarcinoma of the rectum</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 29, 1967</u> , to <u>May 30, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 30, 1967</u> , and that death occurred at <u>12:45</u> M, from causes on and on the date stated above.							
22a. SIGNATURE <u>John S. Harshey</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/30/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>				22d. ADDRESS <u>8400 St Westminster, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/2/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. James Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Dennings Carroll Co., Md.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>C. M. Waltz Box 241 Sykesville, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 2 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>	



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VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06494

05481

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hampstead</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Hanover Pike (Black and Decker)</b>		e. STREET ADDRESS <b>2004 York Road</b>	
3. NAME OF DECEASED (Type or print) <b>CHARLES ELWOOD BOSLEY Sr.</b>		4. DATE OF DEATH Month <b>May</b> Day <b>2</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 22, 1918</b>
9. AGE (In years last birthday) <b>49 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Tool Maker</b>	
11c. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William H. Bosley</b>		14. MOTHER'S MAIDEN NAME <b>Lola May Wilson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>B-10-45/12-5-45 216-07-5723</b>	
17. INFORMANT <b>Mrs. Isabelle C. Bosley, Same as # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>6-10-</b> , 19 <b>67</b> , to <b>5-2-</b> , 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>3/10/</b> 19 <b>67</b> , and that death occurred at <b>4 P</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>M. K. Quinn</b>		22b. DATE SIGNED <b>5/3/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>M. K. Quinn, M.D.</b>		22d. ADDRESS <b>1927 York Road, Tinonium, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>May 5, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Cockeysville, Maryland</b>
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson,</b>		25a. REC'D BY REGISTRAR <b>MAY 5 1967</b>	
ADDRESS <b>1050 York Road Towson, Md. 21204</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

14470

TECHNICAL DRAWING

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THE FOLLOWING INFORMATION IS FOR YOUR INFORMATION ONLY

IT IS NOT TO BE USED FOR ANY OTHER PURPOSE

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06495

CERTIFICATE OF DEATH

06482

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN Ib <u>14 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>1044 W. Goldspring Lane</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edna</u> <u>NEEN</u> <u>Bradley</u>		4. DATE OF DEATH Month Day Year <u>May</u> <u>31</u> <u>19 67</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-27-78</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles Royer</u>	
14. MOTHER'S MAIDEN NAME <u>unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Record</u> Address <u>Springfield State Hospital</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Broncho pneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>years</u> <u>days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>CBS assoc. w/senile brain disease w/psychotic reaction.</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5-17-67</u> , 19 <u>67</u> , to <u>5-31</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5-31</u> , 19 <u>67</u> , and that death occurred at <u>12:00 M</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Ernest Beiser, M.D.</u>		22b. DATE SIGNED <u>5-31-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ernest Beiser, M.D.</u>		22d. ADDRESS <u>Sykesville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>6/2/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MEADOW RIDGE</u>	23d. LOCATION (City or Town) (County) (State) <u>ELK RIDGE MD.</u>
24. FUNERAL DIRECTOR <u>Paul E. Charovetz</u>		25a. REC'D BY REGISTRAR <u>3617 Chestnut Ave.</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE <u>JUN 5 1967</u>	

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in day

1910 to 1911

1911 to 1912

1912 to 1913

1913 to 1914

1914 to 1915

1915 to 1916

1916 to 1917

1917 to 1918

1918 to 1919

1919 to 1920

1920 to 1921

1921 to 1922

1922 to 1923



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06496

06483

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Manchester</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Manchester</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>60 yr</i>		d. STREET ADDRESS <i>S. Main St.</i>	
3. NAME OF DECEASED (Type or print) First <i>Margaret</i> Middle <i>Mary</i> Last <i>Brilhart</i>		4. DATE OF DEATH Month <i>MAY</i> Day <i>26</i> Year <i>1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 25, 1887</i>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hwf.</i>		9b. AGE (In years, last birthday) <i>79</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hwf.</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>Carroll Co. Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Thomas Wells</i>		14. MOTHER'S MAIDEN NAME <i>Harriet Jamison</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>160-16-2276 B</i>	
17. INFORMANT <i>Mr. Walter F. Brilhart, Manchester, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute Heart Failure</i> DUE TO (b) <i>Arteriosclerotic Cardio Vascular Disease</i> DUE TO (c) <i>12/2/62</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2 hrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Carcinoma probably pancreas</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>March</i> , 19 <i>49</i> , to <i>May 26</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>MAY 26</i> , 19 <i>67</i> , and that death occurred at <i>8 p.m.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>W. H. Foard</i>		22b. DATE SIGNED <i>5/26/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>W. H. Foard M.D.</i>		22d. ADDRESS <i>Manchester, Md 21102</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5/29/67</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Manchester Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Manchester Md.</i>	
24. FUNERAL DIRECTOR <i>Tipton-Eline Fun. Home, Hampstead, Md.</i>		25a. REC'D BY REGISTRAR <i>MAY 31 1967</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06497

CERTIFICATE OF DEATH

06484

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Sykesville</b>			c. LENGTH OF STAY IN 1b <b>24y. 7m. 18d.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>4800 Anttana Ave.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Valentine</b> Middle <b>Emily</b> Last <b>Buckingham</b>				4. DATE OF DEATH Month <b>5</b> Day <b>12</b> Year <b>67</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/14/95</b>		9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maine</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Freeland Kenny</b>				14. MOTHER'S MAIDEN NAME <b>Margaret O'Connor Connor</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>247072222</b>		17. INFORMANT Address <b>Springfield Hospital records, Sykesville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)							INTERVAL BETWEEN ONSET AND DEATH <b>hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Manic depressive reaction, manic type.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <b>he</b> (this hospital) attended the deceased from <b>9/22/1942</b> to <b>5/11/1967</b> , that <b>he</b> (we) last saw the deceased alive on <b>5/11/1967</b> , and that death occurred at <b>10:05 a.m.</b> , from causes and on the date stated above.							
22a. SIGNATURE <i>Naci N. Buyukunsal</i>				22b. DATE SIGNED <b>5/11/67</b>		22c. PHYSICIAN'S NAME (Type) <b>Naci N. Buyukunsal, M.D.</b>	
22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>5-15-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc.</b>				25a. REC'D BY REGISTRAR <b>MAY 15 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
06498					06485				
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Sykesville</u>			c. LENGTH OF STAY IN ID <u>13 Years</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Sykesville</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Ridge Road</u>					d. STREET ADDRESS <u>Ridge Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN W. CABLE, 3rd</u>					4. DATE OF DEATH <u>May 8, 1967</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-6-1908</u>		9. AGE (In years last birthday) <u>59</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Law</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>John W. Cable, Jr.</u>					14. MOTHER'S MAIDEN NAME <u>Lutie Betts</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-03-6424</u>		17. INFORMANT <u>Mrs. Ethel Cable Sykesville, Md.</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of skull from mastoid lesion,</u> <u>1960</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bony metastasis of the skull, hemorrhage from</u> DUE TO (c) <u>Left ear, nasal pharynx, anemia, anergasia.</u>								INTERVAL BETWEEN ONSET AND DEATH <u>3/5/67</u> <u>through</u> <u>5/8/67</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>March 5, 1967</u> , to <u>May 8, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 8, 1967</u> , and that death occurred at <u>12:30 A.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Howard E. Hall</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>May 10, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>Howard E. Hall, M.D.</u>				22d. ADDRESS <u>Sykesville, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-10-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lake View Park</u>		23d. LOCATION (City, town or county) (State) <u>Sykesville Md.</u>			
24. FUNERAL DIRECTOR <u>Harry W Haight</u>				ADDRESS <u>Sykesville, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 12 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
06493 CERTIFICATE OF DEATH 06486

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u> c. LENGTH OF STAY IN 1b <u>20 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>206 York St</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u> d. STREET ADDRESS <u>206 York St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																											
3. NAME OF DECEASED (Type or print) <u>MARY</u> First Middle Last		4. DATE OF DEATH <u>MAY 9</u> Month Day Year		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 14 1870</u> Month Day Year		9. AGE (In years last birthday) <u>97</u> Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>											
13. FATHER'S NAME <u>John T. Allison</u>				14. MOTHER'S MAIDEN NAME <u>MARY E. MORRIS</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO.				17. INFORMANT <u>Miss Anna Catridor</u> Address <u>Manchester, Md</u>															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Atherosclerosis</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Decubitus Ulcers</u>																INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)																20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>								20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)															
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>52</u> , to <u>May 9</u> , 19 <u>67</u> , that (II) (we) last saw the deceased alive on <u>Feb 7</u> , 19 <u>67</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.																															
22a. SIGNATURE <u>W. H. Foard</u> M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>																22b. DATE SIGNED <u>5/9/67</u>															
22c. PHYSICIAN'S NAME (Type) <u>W. H. Foard M.D.</u>																22d. ADDRESS <u>Manchester, Md</u>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>May 12 1967</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>BALTO. Co. Md</u>																			
24. FUNERAL DIRECTOR <u>BURQUE FEDERAL HOME</u>				ADDRESS <u>3634 HALLS Rd</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>																			
DATE <u>MAY 15 1967</u>																															

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DEPARTMENT OF HEALTH

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MAY 1951

CERTIFICATE OF DEATH

06487

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1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Finksburg, Md.</u>		c. LENGTH OF STAY IN 1b <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hanover Pike, Greenmount, Md.</u>		d. STREET ADDRESS <u>108 S. East Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Ernest L. Crockett, Sr.</u>		4. DATE OF DEATH <u>May 13, 1967</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/24/1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Produce Market Tangier, Virginia</u>	
13. FATHER'S NAME <u>Edward Crockett</u>		14. MOTHER'S MAIDEN NAME <u>Julie Thomas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-07-6819</u>	
17. INFORMANT <u>Mrs. Eleanor Dougherty</u>		Address <u>21229 421 Wickham Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Unstable Angina</u> DUE TO (c) <u>Arteriosclerotic Cardiovas. Dis.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/25</u> , 19 <u>65</u> , to <u>5/13</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/13</u> , 19 <u>67</u> , and that death occurred at <u>2P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>D. Knight</u>		22b. DATE SIGNED <u>5/13/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Donald A. Knight, M.D.</u>		22d. ADDRESS <u>Greenmount, Md</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/17/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>John A. Moran, Inc. 3000 E. Baltimore St.</u>		25a. REC'D BY REGISTRAR <u>MAY 16 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06501

06488

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>		c. LENGTH OF STAY IN 1b <b>3 1/4 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>46 Charles Street</b>			d. STREET ADDRESS <b>46 Charles Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Raymond E. Cross</b>			4. DATE OF DEATH Month Day Year <b>May 18, 19 67</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <b>SEPARATED</b>	8. DATE OF BIRTH <b>JAN. 23, 1932</b>	9. AGE (In years last birthday) <b>36</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>WESTMINSTER MD</b>	
13. FATHER'S NAME <b>RAYMOND T. CROSS</b>			14. MOTHER'S MAIDEN NAME <b>ANNA BROWN</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES 1951-1953</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>RAYMOND T. CROSS, ADDRESS</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fatty alteration of Liver</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED <b>5/19/67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>5/21/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>WESTERN CHAPEL</b>		23d. LOCATION (City or Town) (County) (State) <b>RURAL, WESTMINSTER, MD</b>	
24. FUNERAL DIRECTOR <b>J. E. Myers, Jr., Westminster, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 22 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

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19220



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06502

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06489

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINISTER</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminister</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SUNNY VALLEY FARM</b>				d. STREET ADDRESS <b>R.D. #5</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ELMER L. DUNCAN</b>				4. DATE OF DEATH Month Day Year <b>5 8 1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 11, 1923</b>		9. AGE (In years lost birthday) <b>43</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Todd Seed</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert W. Duncan</b>				14. MOTHER'S MAIDEN NAME <b>Lillie Ingersoll</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or date of service) <b>yes</b>		16. SOCIAL SECURITY NO. <b>217-18-1307</b>		17. INFORMANT <b>Mrs. Loretta Duncan, same as #2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shotgun wound of face and neck</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot when he went to investigate car parked above house</b>					
20c. TIME OF INJURY Month, Day, Year <b>6:15 5 8 1967</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Farm Home</b>		20f. (City or town) (County) (State) <b>Westminister Carroll Md.</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Werner U. Spitz</b>		EXAMINER'S NAME (Type) <b>WERNER U. SPITZ, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>5-9-67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5-11-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer</b>		23d. LOCATION (City or Town) (County) (State) <b>Carroll Co., Maryland</b>	
24. FUNERAL DIRECTOR <b>C.N. Waltz Box 241, Sykesville, Md. 21784</b>				25a. REC'D BY REGISTRAR <b>MAY 11 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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*[Handwritten signature]*

MA 11 1981

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

06503

06490

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Marblehead</u> c. LENGTH OF STAY IN 1b <u>29 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Longview Nursing Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Union Bridge Md</u> d. STREET ADDRESS <u>2041</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
<b>3. NAME OF DECEASED</b> (Type or print) <u>Elizabeth Jeanette Englar</u> First Middle Last		<b>4. DATE OF DEATH</b> Month <u>May</u> Day <u>19</u> Year <u>1967</u>		<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>July 14, 1884</u>		<b>9. AGE (in years last birthday)</b> <u>82</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>New Windsor, Md.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>							
<b>13. FATHER'S NAME</b> <u>John Engel</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Helene Thinhart</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>220-34-770</u>				<b>17. INFORMANT</b> <u>Frank Englar Union Bridge Md</u> Address			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> DUE TO (b) <u>Arteriosclerotic Cardio Vascular Disease</u> (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>																<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)																<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. <u>  </u> 19 <u>  </u> p.m. <u>  </u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)									
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Apr 19, 1967</u> , to <u>May 19, 1967</u> , that (I) (we) last saw the deceased alive on <u>Apr 19, 1967</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.																			
<b>22a. SIGNATURE</b> <u>Joseph C. Dush M.D.</u>										<b>22b. DATE SIGNED</b> <u>7/19/67</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Joseph C. Dush M.D.</u>				<b>22d. ADDRESS</b> <u>Hampstead Maryland</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>				<b>23b. DATE THEREOF</b> <u>MAY 22 - 1967</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>PIPE CREEK</u>				<b>23d. LOCATION</b> (City, town or county) (State) <u>CARROLL CO MD</u>									
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>D.D. Hertzler &amp; Sons Union Bridge, Md</u>										<b>25a. REC'D BY REGISTRAR</b> <u>MAY 23 1967</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles J. J...</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate has been retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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RECEIVED BY THE OFFICE OF THE ATTORNEY GENERAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06504

CERTIFICATE OF DEATH

06491

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Windsor, Md</u>		d. STREET ADDRESS <u>120 N. MAIN ST.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll County General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Roland</u> Middle <u>J</u> Last <u>English</u>		4. DATE OF DEATH Month <u>5</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 5, 1890</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>2</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GENERAL LABOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Issac English</u>		14. MOTHER'S MAIDEN NAME <u>Anna Elliott</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-26-9694</u>	
17. INFORMANT <u>Mrs. Lee Marie Huff</u>		Address <u>New Windsor, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> DUE TO (b) <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>331X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/1</u> , 19 <u>67</u> , to <u>5/2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/2</u> , 19 <u>67</u> , and that death occurred at <u>8:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Wm. J. Knowlton Jr.</u> M.D.		22b. DATE SIGNED <u>5/2/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>MAY 6, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Foreston Baptist</u>		23d. LOCATION (City or Town) (County) (State) <u>Parkton Carroll Md</u>	
24. FUNERAL DIRECTOR <u>John E. Hoff</u>		25a. REC'D BY REGISTRAR <u>MAY 9 1967</u>	
ADDRESS <u>Hampstead, Md</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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MAY 1983



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06505

CERTIFICATE OF DEATH

06492

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>---</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL -- Sykesville Cy 8m 23d</u>		c. LENGTH OF STAY IN Ib <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>4414 Wrenwood Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>FLORENCE</u> Middle <u>Cockey</u> Last <u>FRETWELL</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>11-17-67</u>
9. AGE (In years lost birthday) <u>99</u> yrs.		10. IF UNDER 1 YEAR Months <u>---</u> Days <u>---</u> Hours <u>---</u> Min <u>---</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEAMSTRESS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. STORE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>AMOS HARRYMAN</u>		14. MOTHER'S MAIDEN NAME <u>ANNE HOWARD</u>	
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>474-16-5299</u>	
17. INFORMANT <u>Springfield Hosp. records</u>		<u>Sykesville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Arteriosclerotic Heart Disease Chronic Brain Dis.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>42 yrs</u> <u>46 yrs</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CBS associated with senile brain disease with psychotic reaction</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>---</u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>8-26-1966</u> to <u>5-19-1967</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>5-19-1967</u> and that death occurred at <u>10:15</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Paul J. Ensor, M.D.</u>		22b. DATE SIGNED <u>5/19/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>PAUL ENSOR - M.D.</u>		22d. ADDRESS <u>533 Hospital Sykesville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/23/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lakeview Mem. Pk.</u>	23d. LOCATION (City or Town) (County) (State) <u>Carroll County Md.</u>
24. FUNERAL DIRECTOR <u>H. W. Jenkins &amp; Sons Co. 4905 York Road Baltimore 12, Maryland</u>		25. REC'D BY REGISTRAR <u>MAY 24 1967</u>	
26. REGISTRAR'S SIGNATURE <u>[Signature]</u>		27. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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RECEIVED OF NEW YORK

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Handwritten text, mostly illegible due to bleed-through from the reverse side of the page. Some words like "NEW YORK" and "RECEIVED" are faintly visible.

Handwritten text at the bottom of the page, including what appears to be a date "JAN 11 1900" and other illegible markings.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06506

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06493

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R.T. 3</b>		d. STREET ADDRESS <b>R.T. 3</b>	
3. NAME OF DECEASED (Type or print) <b>HARRY MELVIN GIGGARD</b>		4. DATE OF DEATH <b>5 14 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 18, 1907</b>
9. AGE (In years last birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Huckster</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Egg Route</b>	
11. BIRTHPLACE (State or foreign country) <b>Carroll Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Adam Giggard</b>		14. MOTHER'S MAIDEN NAME <b>Lizzie Mathias</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-07-4821</b>	
17. INFORMANT <b>Mrs. Ruth Giggard</b>		Address <b>Westminster, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis (acute)</b> DUE TO (b) <b>Sudden</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
21a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		21b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
21c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		21d. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>W. Glenn Speicher</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/17/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Snydersburg Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Snydersburg Carroll Co. Md.</b>	
24. FUNERAL DIRECTOR <b>Tipton - Eline Funeral Home Hampstead, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 17 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		22. DATE SIGNED <b>5-19-67</b>	

212-01-10-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
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1

M

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06507

06494

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodbine</b>		d. STREET ADDRESS <b>Carroll County General Hospital</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CORA V. GOSNELL</b>		4. DATE OF DEATH Month <b>May</b> Day <b>24</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 26, 1889</b>
9. AGE (In years last birthday) yrs. <b>77</b>		10. IF UNDER 1 Year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Carroll Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Milton T. Long</b>		14. MOTHER'S MAIDEN NAME <b>Emma F. ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-16-0712</b>	
17. INFORMANT <b>Mr. Guy E. Grimes Sykesville, Md.</b>		Address <b>Route 3</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332X</b> DUE TO <b>Cerebral thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 22, 1967</b> , to <b>May 24, 1967</b> that (I) (we) last saw the deceased alive on <b>May 24, 1967</b> , and that death occurred at <b>3:20 AM</b> , from causes on and on the date stated above.			
22a. SIGNATURE <b>John S. Harshey</b>		22b. DATE SIGNED <b>5/24/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN S. HARSHEY</b>		22d. ADDRESS <b>8 Archer St. Westminster, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/27/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Morgan Chapel</b>		23d. LOCATION (City or Town) (County) (State) <b>Carroll Co., Md.</b>	
24. FUNERAL DIRECTOR <b>C. M. Waltz Box 241 Sykesville, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 29 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

10136

RECEIVED

10136



*[Faint, mostly illegible handwritten text and markings on lined paper. Some visible words include "RECEIVED", "10136", and "10136". There are also some scribbles and a large "X" mark.]*

*[Faint, mostly illegible handwritten text on the right margin.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06508

CERTIFICATE OF DEATH

06495

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SYKESVILLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL COUNTY GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>152 CARTER ROAD</u>	
3. NAME OF DECEASED (Type or print) <u>DICKSON JAMES GREENFIELD</u>		4. DATE OF DEATH Month <u>5</u> Day <u>12</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 17 1920</u>
9. AGE (In years last birthday) <u>46</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ACCOUNTANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>C. P. A.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>BELFAST NORTHERN IRELAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JAMES D. GREENFIELD</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE A. ADAIR</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>350-16-3811</u>	
17. INFORMANT <u>MISS KATHLEEN E GREENFIELD</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>CARDIAC ARREST</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO <u>ARTERIO SCLEROTIC HEART DISEASE</u> (c) <u>VRS.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>49 MIN</u> <u>10 HRS</u> <u>VRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/12, 1967</u> , to <u>5/12, 1967</u> , that (I) (we) last saw the deceased alive on <u>5/12, 1967</u> , and that death occurred at <u>3:38</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Vincent J. Fiocco, Jr.</u>		22b. DATE SIGNED <u>5/12/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>VINCENT J. FIOCO, JR.</u>		22d. ADDRESS <u>WESTMINSTER, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-15-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		23d. LOCATION (City or Town) (County) (State) <u>Easton, Md.</u>	
24. FUNERAL DIRECTOR <u>Arthur A. Knight, Springfield, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 16 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>			

00000

INDICATE THE DATE

00000

42 min

CHURCH ARREST

Active Information Information 10/12

Active Information Information 10/12

10/12

10/12

MAY 1962

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
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VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06503

06496

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. LENGTH OF STAY IN 1b <u>Maple Grove</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.D. 3</u>		d. STREET ADDRESS <u>Maple Grove</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Sterling J. GREENWOOD</u>		4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 30, 1887</u>
9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carroll Co.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isaiah Greenwood</u>		14. MOTHER'S MAIDEN NAME <u>Ida Horton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-16-2713</u>	
17. INFORMANT <u>Joseph Greenwood</u>		Address <u>Hampstead, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>260X</u> (b) <u>Arterio-Sclerosis C.V. Disease</u> (c) <u>Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>3 hrs</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>0</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1, 1967</u> to <u>5-7, 1967</u> , that (I) (we) last saw the deceased alive on <u>5-1, 1967</u> , and that death occurred at <u>230</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>Maurice C. Porterfield</u>		22b. DATE SIGNED <u>5-8-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>M.C. Porterfield</u>		22d. ADDRESS <u>Hampstead, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/10/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Memorial Gard.</u>		23d. LOCATION (City or Town) (County) (State) <u>Finksburg, Carroll Md.</u>	
24. FUNERAL DIRECTOR <u>Tipton - Eline Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Hampstead, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>MAY 10 1967</u>			

00480

RECEIVED

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19

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VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06510

CERTIFICATE OF DEATH

06497

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>14 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New Windsor</b>		d. STREET ADDRESS <b>Rt. #1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>IDA (NMN) HAYES</b>		4. DATE OF DEATH Month Day Year <b>MAY 1 19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-04-24</b>
9. AGE (In years last birthday) <b>42</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Michael Vogel</b>	
14. MOTHER'S MAIDEN NAME <b>Anna Shulman</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>219-16-7961</b>		17. INFORMANT <b>Records, Springfield State Hospital</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malignant Lymphoma</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>4-17-67</b> , to <b>5-1-67</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>5-1-67</b> , 19 <b>67</b> , and that death occurred at <b>2:15 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Antonius Glahn, M.D.</b>		22b. DATE SIGNED <b>5-3-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Antonius Glahn, M. D.</b>		22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5/6/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemtery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>James E. Bruzdinski</b>		25. REC'D BY REGISTRAR <b>MAY 8 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

1947

00010

Mr. Daniel Gentry

2187

2187

1000 1st Ave. N.

Minneapolis, Minn.

May 1947



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #7 & 13 Film #G389 6/16/67 pc

06511

# CERTIFICATE OF DEATH

07979

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Sykesville</b>				c. LENGTH OF STAY IN 1b <b>19 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Marie J. Houck</b>				4. DATE OF DEATH Month <b>5</b> Day <b>31</b> Year <b>1967</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>2/14/78</b>		9. AGE (In years lost birthday) yrs. <b>89</b>	10. IF UNDER 1 YEAR Months <b>5</b> Days <b>31</b> Hours <b>19</b> Min. <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>San Antonio, Texas</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Samuel S. Jones</b>			
14. MOTHER'S MAIDEN NAME <b>Katie Saunders</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>			
16. SOCIAL SECURITY NO. <b>216-54-6065</b>				17. INFORMANT <b>Springfield Hospital records, Sykesville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO (b) <b>Carcinoma of the urinary bladder</b> DUE TO (c) <b>Chronic brain syndrome associated with senile brain disease with psychotic reaction.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic brain syndrome associated with senile brain disease with psychotic reaction.</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <del>the</del> (this hospital) attended the deceased from <b>5/12/</b> , 1967, to <b>5/31/</b> , 1967, that <del>it</del> (we) last saw the deceased alive on <b>5/31/</b> 1967, and that death occurred at <b>6:50 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Renato R. Espina, M.D.</b>				22b. DATE SIGNED <b>6/1/67</b>		22c. PHYSICIAN'S NAME (Type) <b>Renato R. Espina, M. D.</b>	
22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>6/4/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>West Liberty Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Rutledge, Md</b>			
24. FUNERAL DIRECTOR <b>Herbert E. Nutter 3035 W. North Ave</b>				25a. REC'D BY REGISTRAR <b>JUN 6 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon, papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
06512  
06499  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>UNION BRIDGE</b>		c. LENGTH OF STAY IN 1b <b>YEARS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>BENEDUM ST.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>UNION BRIDGE</b>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM BURGESS HYDE</b>		d. STREET ADDRESS <b>BENEDUM ST.</b>	
4. DATE OF DEATH Month <b>MAY</b> Day <b>12</b> Year <b>1967</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN 23-1887</b>
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months <b>80</b> Days <b>80</b> Hours <b>80</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RAILROAD SHOPS</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WILLIAM HYDE</b>		14. MOTHER'S MAIDEN NAME <b>ADDIE HARRIS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES W W I</b>		16. SOCIAL SECURITY NO. <b>213-10-9226</b>	
17. INFORMANT <b>HILDA HYDE</b>		Address <b>UNION BRIDGE MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Abdominal Carcinomatosis</b> DUE TO (b) <b>Carcinoma of the Stomach</b> DUE TO (c) <b>3 Months.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 Months.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb</b> , 19 <b>67</b> , to <b>5/12/67</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>May 11</b> , 19 <b>67</b> , and that death occurred at <b>11 P M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>J. H. Caricofe</b>		22b. DATE SIGNED <b>5/12/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>J H CARICOFE</b>		22d. ADDRESS <b>UNION BRIDGE MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>MAY 15-1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>CHAPEL</b>		23d. LOCATION (City, town or county) (State) <b>LIBERTYTOWN RURAL MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>D N Hartgen</b>		25a. REC'D BY REGISTRAR <b>MAY 16 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

06513

06498

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>119 Springfield Ave.</u>				d. STREET ADDRESS <u>119 Springfield Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>Ida W. Jones</u>				4. DATE OF DEATH Month <u>May</u> Day <u>28</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-5-1882</u>	
9. AGE (In years last birthday) <u>85 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Artist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Art</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Nickolas Jones</u>			
14. MOTHER'S MAIDEN NAME <u>Julia Webb</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>219-20-7778</u>				17. INFORMANT <u>Miss Elsie Jones - Sykesville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes, Arteriosclerosis, generalized;</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral thrombosis, Cardiac failure,</u> DUE TO (c) <u>Chronic brain syndrome.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7/12/66 through 5/28/67</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 12, 1966</u> , to <u>May 28, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 28, 1967</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Howard E. Hall</u>				22b. DATE SIGNED <u>May 31, 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>Howard E. Hall, M.D.</u>	
22d. ADDRESS <u>Sykesville, Maryland</u>				22e. ADDRESS <u>Sykesville, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-31-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Springfield Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Sykesville Md.</u>	
24. FUNERAL DIRECTOR <u>Harry W. Haight</u>				25a. REC'D BY REGISTRAR <u>Nicholas Judge</u>			
25b. REGISTRAR'S SIGNATURE <u>Nicholas Judge</u>				25c. DATE <u>JUN 5 1967</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06514

CERTIFICATE OF DEATH

06500

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Sykesville</b>		c. LENGTH OF STAY IN TB <b>3mo. 15 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>2719 Edmondson Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>SADIE MAE KEEVE</b>				4. DATE OF DEATH Month Day Year <b>5 15 1967</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>3-31-1912</b>		9. AGE (In years last birthday) yrs. <b>55</b>	IF UNDER 1 YEAR Months Days Hours Min. <b>15 15 67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (County & State, or foreign country) <b>London, Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>March Williams</b>				14. MOTHER'S MAIDEN NAME <b>Roberta Baldwin</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT Address <b>Records, Springfield State Hospital</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Miliary &amp; disseminated pulmonary tuberculosis</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <b>days &amp; years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (x) (this hospital) attended the deceased from <b>1-30</b> , 19 <b>67</b> , to <b>5-15</b> , 19 <b>67</b> , that (x) (we) last saw the deceased alive on <b>5-15-1967</b> , and that death occurred at <b>8:50am</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Julian Radzykewycz</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>5-15-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Julian Radzykewycz</b>				22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-18-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Balt. Nat'l Cen.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR <b>Morton E. Dyett F. H.</b>				25a. REC'D BY REGISTRAR <b>1701 LAURENS ST.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

DATE **MAY 17 1967**

3-31-1915

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James M. Smith

James M. Smith

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06515

## CERTIFICATE OF DEATH

06501

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <div style="text-align: right;">MARYLAND</div>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster x22 21157</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Carroll County General Hospital</b>		d. STREET ADDRESS <b>Route #6, Box 111</b>	
3. NAME OF DECEASED (Type or print) <div style="display: flex; justify-content: space-between;"><div>First <b>Anthony</b></div><div>Middle <b>C.</b></div><div>Last <b>Kissell</b></div></div>		4. DATE OF DEATH <div style="display: flex; justify-content: space-between;"><div>Month <b>May</b></div><div>Day <b>20</b></div><div>Year <b>1967</b></div></div>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/15/26</b>
9. AGE (In years lost birthday) <b>40</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Trans World Airlines</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Matthew Kissell</b>	
14. MOTHER'S MAIDEN NAME <b>Anna Balcaitis</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>	
16. SOCIAL SECURITY NO. <b>220-12-9435</b>		17. INFORMANT <b>Mrs. Dolores P. Kissell Rt. 6, Box 111</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adeno-Carcinoma, jejunum</b> DUE TO (b) <b>Pulmonary and cerebral metastasis</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>5/14</b> , 19 <b>67</b> , to <b>5/20</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>5/20</b> , 19 <b>67</b> , and that death occurred at <b>2:15 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>John S. Harshey</b>		22b. DATE SIGNED <b>5/20/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN S. HARSHEY M.D.</b>		22d. ADDRESS <b>8 Archer St. Westminster, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5/24/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>		25. REC'D. BY REGISTRAR <b>MAY 23 1967</b>	
26. ADDRESS <b>4107 Wilkens Ave. 21229</b>		27. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please retrace carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06516

## CERTIFICATE OF DEATH

06502

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN lb <u>11 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>3313 Chestnut Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lula Frances Leaf</u>		4. DATE OF DEATH Month Day Year <u>May 29 19 67</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-16-80</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mill worker (weaver)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cotton Mill</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Cornelius Leaf</u>		14. MOTHER'S MAIDEN NAME <u>Christine Klumper</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-07-6736</u>	
17. INFORMANT <u>Record</u>		Address <u>Springfield State Hospital</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO (b) <u>General weakness and cachectic condition</u> DUE TO (c) <u>decubitus ulcers &amp; fungus infection under l. breast.</u> unknown			INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CBS associated with senile brain disease with psychotic reaction</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5-18-67</u> , 19 <u>67</u> , to <u>5-29</u> , 19 <u>67</u> that (I) (we) lost the deceased on <u>5-29-67</u> , 19 <u>67</u> , and that death occurred at <u>1:45</u> A.M. from causes on and on the date stated above.			
22a. SIGNATURE <u>H. E. Connor</u>		22b. DATE SIGNED <u>5-29-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>H. E. Connor, M.D.</u>		22d. ADDRESS <u>Sykesville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6/1/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Grace Methodist Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Chestnut Ridge, Md.</u>
24. FUNERAL DIRECTOR <u>BURGER FUNERAL HOME</u>		25. REC'D BY REGISTRAR <u>JUN 2 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>James Judge</u>		25c. ADDRESS <u>2431 Falls Road</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the ban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06517

# CERTIFICATE OF DEATH

06503

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodbine-Rural</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll County General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SAMUEL</u> Middle <u>H.</u> Last <u>LEATHERWOOD, SR.</u>		4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 7, 1902</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Howard Leatherwood</u>		14. MOTHER'S MAIDEN NAME <u>Lillie G. Fowble</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-36-2059</u>	
17. INFORMANT <u>Mrs. Ruth B. Leatherwood</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1993 X</u> DUE TO <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pneumonia</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive arteriosclerotic cardiovascular disease</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 3, 1967</u> , to <u>May 13, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 13, 1967</u> , and that death occurred at <u>3:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John S. Harshey</u> M.D.		22b. DATE SIGNED <u>5/13/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>		22d. ADDRESS <u>8 Anchor St Westminster, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/16/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lakeview Mem. Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Carroll Co., Md.</u>
24. FUNERAL DIRECTOR <u>C. M. Waltz Box 241 Sykesville, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 16 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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100000

CERTIFICATE OF TITLE

100000

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06518-

## CERTIFICATE OF DEATH

06504

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Sykesville</b>		c. LENGTH OF STAY IN IB <b>39 yrs. 9 mo. 4 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>E.</b> Last <b>Lefever</b>		4. DATE OF DEATH Month <b>5</b> Day <b>8</b> Year <b>1967</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/7/86</b>
9. AGE (In years lost birthday) yrs. <b>80</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none known</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel Lefever</b>		14. MOTHER'S MAIDEN NAME <b>Mary Catherine Ward</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none known</b>	
17. INFORMANT <b>Springfield Hospital records, Sykesville, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma of stomach with multiple</b> DUE TO (b) <b>metastases.</b> DUE TO (c) <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mental defective, undifferentiated</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>49</b> (this hospital) attended the deceased from <b>8/17</b> , 19 <b>67</b> to <b>5/8</b> , 19 <b>67</b> , that <b>41</b> (we) last saw the deceased alive on <b>5/8</b> , 19 <b>67</b> , and that death occurred at <b>6:25 p.m.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Alfredo M. Labrit</b>		22b. DATE SIGNED <b>5/8/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR ALFREDO M LABRIT</b>		22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>5/11/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>RIVERVIEW CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>WILMINGTON, WASH., Md</b>
24. FUNERAL DIRECTOR <b>Alfred Leaf Williamsport, Md</b>		25a. REC'D BY REGISTRAR <b>MAY 11 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove from pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TESTIMONY OF DEATH

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06513

## CERTIFICATE OF DEATH

06505

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BUCHER JOHN ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GEORGE ROBERT LOWE</u>		4. DATE OF DEATH <u>MAY 5, 1967</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 22 - 1888</u>
9. AGE (In years last birthday) <u>78</u> YRS.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOREMAN QUARRY CEMENT PLANT</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>WILLIAM J. LOWE</u>		14. MOTHER'S MAIDEN NAME <u>EMMA SHARRER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>21603-1704</u>	
17. INFORMANT <u>5882 HAL WYN</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatous</u> (b) <u>Rt. bronchus - original site</u> (c) <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 20</u> , 19 <u>67</u> , to <u>5/5/67</u> , 19 <u>67</u> , that (I) (we) saw the deceased alive on <u>5/4/67</u> , 19 <u>67</u> , and that death occurred on <u>5/5/67</u> , 19 <u>67</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>M. E. Robertson</u>		22b. DATE SIGNED <u>5/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. E. ROBERTSON</u>		22d. ADDRESS <u>New Windsor Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>5/8/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>KRIDERS CEM. WESTMINSTER MD</u>	23d. LOCATION (City or Town) _____ (County) _____ (State) _____
24. FUNERAL DIRECTOR <u>D. Hartblut sons</u>		25. RECORD BY REGISTRAR <u>MAY 9 1967</u>	
26. ADDRESS <u>UNION BRIDGE MD</u>		27. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

00213

CHRONOLOGICAL

1919

CHRONOLOGICAL  
INDEX  
1919



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06520

## CERTIFICATE OF DEATH

06506

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>6 mos./ 21 das.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>1021 N. Monroe Street</b>	
3. NAME OF DECEASED (Type or print) <b>Mabel</b>		4. DATE OF DEATH Month <b>May</b> Day <b>21</b> , Year <b>1967</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>11-2-1919</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>47</b> yrs.
11. BIRTHPLACE (County & State, or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Manney Chestnut - dec.</b>		14. MOTHER'S MAIDEN NAME <b>Millie Johnson - dec.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Springfield State Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral aneurysm Ruptured</b> DUE TO <b>Accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Hypertensive cardiac vascular disease</b> DUE TO <b>Chronic Arteriosclerosis</b> (c)			INTERVAL BETWEEN ONSET AND DEATH <b>months</b> <b>years</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain syndrome of psychotic reaction.</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11-1-66</b> , 19 <b>to</b> <b>5-21-67</b> , 19 <b>that (I) (we) last saw the deceased alive on</b> <b>5-21-67</b> , 19 <b>and that death occurred at</b> <b>2:52 a.m.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Glocrito G. Sagisi</b>		22b. DATE SIGNED <b>5/21/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Glocrito G. Sagisi, M.D.</b>		22d. ADDRESS <b>Springfield State Hospital, Sykesville, Maryland 21784</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>5/21/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Ann's</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore</b>
24. FUNERAL DIRECTOR <b>Marshall P. Hays</b>		25a. REC'D BY REGISTRAR <b>MAY 25 1967</b>	
ADDRESS <b>638 N. Calvert St</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

06521

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06507

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINISTER</b> c. LENGTH OF STAY IN TB <b>Westminister</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Carroll County General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminister</b> d. STREET ADDRESS <b>RD #5 - Box 281-B</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>GRANVILLE E. MCCARTNEY</b>		4. DATE OF DEATH Month Day Year <b>5 8 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 2, 1939</b> 9. AGE (In years last birthday) <b>28</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dispatcher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Howard Johnson</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ernest McCartney</b>		14. MOTHER'S MAIDEN NAME <b>Audrey Hall</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-38-1747</b>	
17. INFORMANT <b>Mrs. Sylvia M. McCartney</b>		Address <b>same as #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple injuries</b> 8164 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Multiple injuries</b> (c) <b>Multiple injuries</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver in auto-auto collision - Old Washington Road</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>5:55</b> p.m. <b>5 8 1967</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>Carroll Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Werner U. Spitz</b> EXAMINER'S NAME (Type) <b>WERNER U. SPITZ, M.D.</b>		22. DATE SIGNED <b>5-9-67</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>5-12-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Meadow Ridge Mem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Howard Co., Maryland</b>
24. FUNERAL DIRECTOR <b>C.M. Waltz, Box 241, Sykesville, Md. 21784</b>		25a. REC'D BY REGISTRAR <b>May 11 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06522

05508

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>—</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN IB <b>6 mos./23 das</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21218</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>				e. STREET ADDRESS <b>3815 Elkader Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Anna Mary Doonan MILHOLLAND</b>				4. DATE OF DEATH <b>May 14, 1967</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-8-03</b>	9. AGE (In years last birthday) <b>63</b> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Michael Doonan - dec.</b>				14. MOTHER'S MAIDEN NAME <b>Mary Carey - dec.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>none</b>			16. SOCIAL SECURITY NO. <b>212-10-4974</b>		17. INFORMANT <b>Springfield State Hospital Records</b> Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure.</b> DUE TO (b) <b>Arteriosclerotic cardiovascular disease.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Involuntional Psychotic Reaction.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>months</b> <b>years</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>W. Glenn Speicher, M.D.</b> EXAMINER'S NAME (Type)				22. DATE SIGNED <b>5-14-67</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address <b>Springfield State Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/18/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR <b>John A. Moran, Inc. 3000 E. Baltimore Street</b>				25a. REC'D BY REGISTRAR <b>MAY 16 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

02502

02502





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MDARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06523

CERTIFICATE OF DEATH

06509

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>			c. LENGTH OF STAY IN IB <b>4wks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Brookfield Manor Nursing Home</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HENRY HERMAN MILLER</b> First Middle Last				4. DATE OF DEATH Month <b>5</b> Day <b>11</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-4-1890</b>	9. AGE (In years lost birthday) <b>77 yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. office Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>J.W. Woolford</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Emelia Miller</b>				14. MOTHER'S MAIDEN NAME <b>Mary Bertha Meyers</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-09-4994</b>		17. INFORMANT Address <b>Miss Katherine E. Miller 5010 Kenwood Ave</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-vascular accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (1) (this hospital) attended the deceased from <b>4/20</b> , 19 <b>66</b> , to <b>5/11</b> , 19 <b>67</b> , that (1) (we) lost saw the deceased alive on <b>5/11</b> , 19 <b>67</b> , and that death occurred at <b>5:00 P.</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Julius Chapko</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5/11/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Julius Chapko</b>				22d. ADDRESS <b>8526 G. Road Westminster Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-15-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Co. Md.</b>		
24. FUNERAL DIRECTOR <b>Cassahn Funeral Home 7401 Belair Road</b>				25a. REGISTERED DATE <b>MAY 15 1967</b>			
				25b. REGISTRAR'S SIGNATURE <b>Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06524

CERTIFICATE OF DEATH

06510

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Airy</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>611 S. Main St.</b>				d. STREET ADDRESS <b>611 S. Main St.</b>			
3. NAME OF DECEASED (Type or print) First <b>Barbara</b> Middle <b>Ellen</b> Last <b>Moxley</b>				4. DATE OF DEATH Month <b>May</b> Day <b>31</b> Year <b>1967</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Jan. 23, 1909</b>		9. AGE (In years last birthday) yrs. <b>58</b>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teller</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bank</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Mt. Airy, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Simon</b>				14. MOTHER'S MAIDEN NAME <b>Anna Brashears</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-12-2213</b>		17. INFORMANT <b>E. Gaver Moxley,</b>		Address <b>Item 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Metastatic Carcinoma</b> DUE TO (c) <b>Carcinoma right breast</b>							INTERVAL BETWEEN ONSET AND DEATH <b>8 hours</b>  <b>5 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____ 19____		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>August</b> , 19 <b>67</b> , to <b>5/31/</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>5/31/67</b> 19____, and that death occurred at <b>10a.m.</b> from causes and on the date stated above.							
22a. SIGNATURE <i>Gilcin F. Meadors</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>6/1/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Gilcin F. Meadors, M.D.</b>				22d. ADDRESS <b>810 Toll House Ave. Frederick, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 2, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pine Grove</b>		23d. LOCATION (City or Town) (County) (State) <b>Mt. Airy, Md.</b>	
24. FUNERAL DIRECTOR <b>Olin L. Molesworth, Damascus, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>JUN 5 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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1. PLACE OF DEATH a. COUNTY <u>Carroll</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hampstead MD</u>		c. LENGTH OF STAY in 1b <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hillcrest Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EVERETT R. Murray</u>		4. DATE OF DEATH <u>May 12 1967</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 10, 1886</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Whitfield Murray</u>		14. MOTHER'S MAIDEN NAME <u>Sallie E. PRICE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-34-5792</u>	
17. INFORMANT <u>E. Carroll Murray</u>		Address <u>Hampstead MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 26, 1967</u> to <u>May 12, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 11, 1967</u> , and that death occurred at <u>5:45 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph E. Bush MD</u>		22b. DATE SIGNED <u>5/12/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>		22d. ADDRESS <u>Hampstead Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 15, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hampstead Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hampstead, Md.</u>	
24. FUNERAL DIRECTOR <u>Tipton - Eline Funeral Home Hampstead, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 15 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE	

522

June 11

Wingfield MD 1/4

Willard Ave

Everett R

Murray

May 12

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junction 80

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Whitfield Murray

Sells F Price

agriculture (and G) Maryland 1824

no - 20-1-1825 F (and) Murray Wingfield MD

Chronic Myocarditis

Chronic Myocarditis

X

March 26 03 May 12 63

May 12 63

For E. B. 1824

X

Wingfield Maryland

7/1/63

For E. B. 1824

May 12 63

For E. B. 1824



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

06526

06512

<b>1. PLACE OF DEATH</b> a. COUNTY <u>CARROLL</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> c. LENGTH OF STAY IN 1b <u>12 YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>48 W. GEORGE ST.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> d. STREET ADDRESS <u>48 W. GEORGE ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>HENRY AUGUSTUS RICKLE</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>MAY 19 1967</u>				
<b>5. SEX</b> <u>MALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>AUG 16 1883</u>	<b>9. AGE</b> (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>FARMER</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>CARROLL MARYLAND</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA.</u>			
<b>13. FATHER'S NAME</b> <u>JOHN E MANUAL RICKLE</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>MARY ELLA HARMAN</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>217-36-2995A</u>		<b>17. INFORMANT</b> <u>REBA POOLE</u> Address <u>48 W. GEORGE ST. MD. WESTMINSTER</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONITIS</u> DUE TO (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO (c) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> T DAVI 4 YEAR							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>MAY 19 1967</u> <b>to</b> <u>MAY 19 1967</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>MAY 19 1967</u> , <b>and that death occurred at</b> <u>1034 PM</u> , <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Daniel I Welliver</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				<b>22b. DATE SIGNED</b> <u>5-14-67</u> MD			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>DANIEL I. WELLIVER</u>				<b>22d. ADDRESS</b> <u>19 RIDGE RD WESTMINSTER</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>5/25/67</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>ST. JOHN'S CATHOLIC CEM. WESTMINSTER MD.</u>			
<b>23d. LOCATION (City, town or county)</b>		<b>(State)</b>		<b>23e. REC'D BY REGISTRAR</b>			
<b>24. FUNERAL DIRECTOR</b> <u>J. E. Myers, Jr. Westminster, MD</u>		<b>25a. DATE</b> <u>MAY 23 1967</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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JANUARY 12 1962  
NEW GEORGETOWN  
HENRY AUGUSTUS PICKER  
WHITE WITTS  
FARMER  
JOHN FARMER  
ALL INFORMATION  
CONJECTIVE THAT  
PETERSON  
MAY 22 1962  
DANIEL I. WELLS  
PETERSON

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
06527 CERTIFICATE OF DEATH 06513									
1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Greenmount</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Greenmount, Md.</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Greenmount</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Emory</b>			First <b>E</b> Middle <b>Rill</b> Last		4. DATE OF DEATH <b>May 4 19 67</b>		Month <b>May</b> Day <b>4</b> Year <b>19 67</b>		
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/3/ 1891</b>		9. AGE (in years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Carroll County Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>George W. Rill</b>					14. MOTHER'S MAIDEN NAME <b>Laura Barber</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>S.S.219-20-3873</b>		17. INFORMANT <b>Mrs. Alice Rill Greenmount, Maryland</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic Cardio Vascular Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. --- p.m. --- 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>4/26</b> , 19 <b>66</b> , to <b>6/4/67</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>May 1</b> , 19 <b>67</b> , and that death occurred at <b>7:30 a.m.</b> from the causes and on the date stated above.									
22a. SIGNATURE <i>Joseph E. Bush M.D.</i>					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5/4/67</b>		
22c. PHYSICIAN'S NAME (Type) <b>Joseph E. Bush M.D.</b>					22d. ADDRESS <b>117 S. Main St. Hampstead, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 7, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wesley Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Hampstead, Carroll Co. Md.</b>			
24. FUNERAL DIRECTOR <b>Tipton - Eline Funeral Home Hampstead, Md.</b>					25a. REC'D BY REGISTRAR <b>MAY 8 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
06528						CERTIFICATE OF DEATH						06514	
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> c. LENGTH OF STAY IN 1b <u>10 Months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Longview Nursing Home</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster Maryland</u> d. STREET ADDRESS <u>121 Willis Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Evelyn</u> Middle <u>Jackson</u> Last <u>Pinker</u>						4. DATE OF DEATH Month <u>MAY</u> Day <u>3</u> Year <u>1967</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 3 1877</u>		9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>9</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher Public Schools</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Laesburg Virginia</u>		11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>JAMES F. PINKER</u>						14. MOTHER'S MAIDEN NAME <u>SUSAN JACKSON</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>216-4676377</u>		17. INFORMANT Address <u>121 Willis St</u> <u>Evelyn L. Mather Westminster MD</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> DUE TO <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>?</u> DUE TO (c) <u>?</u>										INTERVAL BETWEEN ONSET AND DEATH <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>June 5, 1966</u> to <u>May 3, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 1967</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>Joseph E. Bush MD</u>						22b. DATE SIGNED <u>May 3 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>					
22d. ADDRESS <u>HAMPSTEAD Maryland</u>						22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>5/6/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Westminster, Md</u>					
24. FUNERAL DIRECTOR <u>J. S. Murre Jr.</u>						ADDRESS <u>Westminster, Md</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
DATE <u>MAY 8 1967</u>													

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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 06523 CERTIFICATE OF DEATH 06515																		
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Winfield</u> c. LENGTH OF STAY IN 1b <u>5 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>P.O BOX 210 A, SYKESVILLE, MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WINFIELD</u> d. STREET ADDRESS <u>P.O BOX 210 A SYKESVILLE,</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) <u>Fredrick Schrodetzki</u> First <u>A.</u> Middle <u>S.</u> Last <u>Schrodetzki</u>			4. DATE OF DEATH <u>May 8 1967</u> Month <u>May</u> Day <u>8</u> Year <u>1967</u>		9. AGE (In years) <u>56</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday Months Days Hours Min.													
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 14, 1911</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fresh Fruit</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>GROCERY</u>				11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>						
13. FATHER'S NAME <u>WILLIAM SCHRODETZKI</u>					14. MOTHER'S MAIDEN NAME <u>ANNIE BECK</u>					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <u>215-05-7720</u>			17. INFORMANT <u>MRS LOUISE SCHRODETZKI</u> Address <u>P.O. BOX 210A SYKESVILLE, MD</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Myocardial Infarction</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs</u>				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>																		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)														20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)										
21. I certify that (I) (this hospital) attended the deceased from <u>June 15, 1966</u> to <u>May 8, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 5, 1967</u> , and that death occurred at <u>9:15 M.</u> from the causes and on the date stated above.																		
22a. SIGNATURE <u>W. Martin</u> ATTENDING M.D. <input checked="" type="checkbox"/> PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>May 8 - 67</u>																		
22c. PHYSICIAN'S NAME (Type) <u>W. Martin</u> 22d. ADDRESS <u>W. Martin</u>																		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>MAY 11, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>				23d. LOCATION (City, town or county) (State) <u>RITCHIE HWY, BALTO, MARYLAND</u>								
24. FUNERAL DIRECTOR <u>GEORGE J. GONCE, 4001 RITCHIE HWY, BALTO, MD.</u>						25a. REC'D BY REGISTRAR <u>MAY 11 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>										

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VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06530

06516

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. LENGTH OF STAY IN 1b <u>1 WEEK</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL CO. GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>—</u>	
3. NAME OF DECEASED (Type or print) First <u>BESSIE</u> Middle <u>MAE</u> Last <u>SHRY</u>		4. DATE OF DEATH Month <u>5</u> Day <u>19</u> Year <u>19 67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-1-1891</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM B FAWLEY</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET WRIGHT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-28-1048</u>	
17. INFORMANT <u>DONALD SHRY</u>		Address <u>TANEY TOWN MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART</u> DUE TO (c) <u>DISEASE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u>  <u>YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>DIABETES MELLITUS</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/11</u> , 19 <u>67</u> , to <u>5/19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/19</u> , 19 <u>67</u> , and that death occurred at <u>1:30</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>Vincent J. Fiocco</u>		22b. DATE SIGNED <u>5/19/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>VINCENT J. FIOCCO</u>		22d. ADDRESS <u>WESTMINSTER MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>MAY 22-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MONOCACY</u>	23d. LOCATION (City or Town) (County) (State) <u>BEALLS VILLE MD</u>
24. FUNERAL DIRECTOR <u>DD Hartzler &amp; Sons Union Bridge Md</u>		25a. REC'D BY REGISTRAR <u>MAY 23 1967</u>	25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06531

## CERTIFICATE OF DEATH

06517

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Pennsylvania</u> b. COUNTY <u>York</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>		c. LENGTH OF STAY IN 1b <u>4 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hannu Pa</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Robert Rill Road</u>				d. STREET ADDRESS <u>14 1/2 Orchard Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George William STEGER</u>				4. DATE OF DEATH Month Day Year <u>May 22 1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 6 1896</u>		9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll County Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Steger</u>				14. MOTHER'S MAIDEN NAME <u>Mary Dick</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes World War I</u>		16. SOCIAL SECURITY NO. <u>218-32-5025</u>		17. INFORMANT <u>Mrs Lottie Steger, Hannu Pa</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> DUE TO <u>Hypertensive Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 4</u> , 19 <u>67</u> , to <u>May 22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>May 22</u> , 19 <u>67</u> , and that death occurred at <u>9:15 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Joseph E. Bush MD</u>				22b. DATE SIGNED <u>May 22 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>	
22d. ADDRESS <u>Hampstead Maryland</u>							
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/25/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Immanuel Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Manchester, Carroll, Md.</u>	
24. FUNERAL DIRECTOR <u>Tipton - Eline Funeral Home Hampstead, Md.</u>				25a. REC'D BY REGISTRAR <u>MAY 25 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CONFIDENTIAL

100-100000

[Faint, mostly illegible text covering the majority of the page, likely bleed-through from the reverse side. Some fragments are visible, such as "CONFIDENTIAL" and "100-100000".]



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06532

06518

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b> c. LENGTH OF STAY IN 1b <b>Westminster</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Carroll County General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b> d. STREET ADDRESS <b>Route 6</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Aubrey J. Stem, Jr.</b>				4. DATE OF DEATH Month <b>5</b> Day <b>22</b> Year <b>19 67</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 23, 1909</b>	
9. AGE (In years last birthday) <b>58 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Business Executive</b>		11. BIRTHPLACE (State or foreign country) <b>Carroll Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Aubrey J. Stem</b>				14. MOTHER'S MAIDEN NAME <b>Grace Frizzell</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-32-1132</b>		17. INFORMANT <b>Mrs. Edith C. Stem</b> Address <b>Same As #2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4321</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
22. DATE SIGNED <b>5/23/67</b>		23. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)					
24. ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>		25. DATE SIGNED <b>5/23/67</b>					
26. EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		27. ADDRESS <b>C. M. Waltz Box 241 Sykesville, Md.</b>					
28. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		29. DATE THEREOF <b>5/26/1967</b>		30. NAME OF CEMETERY OR CREMATORY <b>Ebenezer Cemetery</b>		31. LOCATION (City or Town) (County) (State) <b>Carroll Co., Md.</b>	
32. FUNERAL DIRECTOR <b>C. M. Waltz</b>		33. ADDRESS <b>Box 241 Sykesville, Md.</b>		34. REC'D BY REGISTRAR <b>MAY 29 1967</b>		35. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>	

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
 Item #1a & 2b & e Film #G389 6/16/67 pc

06533

**CERTIFICATE OF DEATH**

06758

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Howard</u> <u>Carroll</u> <span style="float:right">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT AIRY</u>		c. LENGTH OF STAY IN 1b <u>131</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT AIRY</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rt 2 Box 386 MT AIRY Md</u>				d. STREET ADDRESS <u>Rt 2 Box 386 MT AIRY Md</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Clifton</u> <u>Curtis</u> <u>Stephens</u>				<b>4. DATE OF DEATH</b> Month <u>May</u> Day <u>26</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. B. DATE OF BIRTH <u>March 6 1902</u>		9. AGE (In years last birthday) <u>65</u> yrs. <div style="display: flex; justify-content: space-between;"> <span>IF UNDER 1 YEAR</span> <span>IF UNDER 24 HRS.</span> </div>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Harmon</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Fredericksburg Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Harmon B Stephens</u>			
14. MOTHER'S MAIDEN NAME <u>Emma Jane Curtis</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>587-03-9158</u>			
17. INFORMANT <u>Ethel B Stephens</u>		Address <u>Rt 2 Box 386 MT AIRY</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO (b) <u>Arteriosclerotic Cardio-Vascular Disease with Severe Hypertension</u> DUE TO (c) <u>5 years Plus</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that (I) (this hospital) attended the deceased from <u>May 1, 1964</u> , 19 <u>67</u> to <u>May 26</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>May 25</u> , 19 <u>67</u> , and that death occurred at <u>7:45 A.M.</u> from causes on and on the date stated above.					
22a. SIGNATURE <u>M. McKendree Boyer</u>		22b. DATE SIGNED <u>May 26, 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>M. McKendree Boyer, M. D.</u>			
22d. ADDRESS <u>9701 Church Street</u>		<u>Damascus, Maryland.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-29-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>			
23d. LOCATION (City or Town) _____ (County) _____ (State) _____		<u>Bethesda, Maryland</u>					
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 1 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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## CERTIFICATE OF DEATH

06534

06519

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY IN lb <b>22 yrs./10 mos.</b>		d. STREET ADDRESS <b>716 Sunhill Rd.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Francis Joseph SULLIVAN</b>		4. DATE OF DEATH Month Day Year <b>May 26, 19 67</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-29-1910</b>
9. AGE (In years last birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Marble cutter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Stone</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George L. Sullivan</b>		14. MOTHER'S MAIDEN NAME <b>Mattie Ogle</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Springfield State Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause—per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>far advanced Pulmonary Tbc</b> DUE TO (b) <b>bilateral; active</b> DUE TO (c) <b>years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Schizophrenia, marked deterioration.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>7-7-44</b> , 19__, to <b>5-26-67</b> , 19__, that (I) (we) last saw the deceased alive on <b>5-26-67</b> , 19__, and that death occurred at <b>9:40 P.m.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Antonius Glahn</b>		22b. DATE SIGNED <b>5-27-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Antonius Glahn, M.D.</b>		22d. ADDRESS <b>Springfield State Hospital, Sykesville, Maryland 21771</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>5-29-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery, Balto.</b>	23d. LOCATION (City or Town) (County) (State) <b>Md.</b>
24. FUNERAL DIRECTOR <b>Harry W. Haight Sykesville, Md.</b>		25a. REC'D BY REGISTRAR <b>MAI 31 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>James Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06535

## CERTIFICATE OF DEATH

06520

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>—</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Sykesville</b>		c. LENGTH OF STAY IN lb <b>1yr. 9mo.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>			d. STREET ADDRESS <b>1325 Homestead Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Teresa</b> Last <b>Suter</b>			4. DATE OF DEATH Month <b>5</b> Day <b>23</b> Year <b>19 67</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/25/83</b>	9. AGE (In years lost birthday) yrs. <b>83</b>	IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>	
13. FATHER'S NAME <b>Edward Toney Fortney</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Quinn</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-03-2862</b>		17. INFORMANT Address <b>Springfield Hospital records, Sykesville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO (b) <b>Coronary arteriosclerosis with old healed left ventricle infarct.</b> DUE TO (c) <b>ventricle infarct.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Weeks</b> <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction.</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m. <b>—</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>8/23/1965</b> , to <b>5/23/1968</b> , that <del>he</del> (we) last saw the deceased alive on <b>5/23/1967</b> , and that death occurred <b>6:45 PM</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>Renato R. Espina, M.D.</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>5/24/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Renato R. Espina, M. D.</b>		22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5/27/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>	23d. LOCATION (City or Town) <b>Baltimore</b>	(County)	(State) <b>Md</b>
24. FUNERAL DIRECTOR <b>J. Melville Jenkins 2713 Kirk Ave.</b>			25a. REC'D BY REGISTRAR <b>MAY 29 1967</b>	25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06536

## CERTIFICATE OF DEATH

06521

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Sykesville</b> c. LENGTH OF STAY IN lb <b>9 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRINGFIELD STATE HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CITY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1006 N. Castle St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>STEVEN (NMN) TALACH</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>29</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/5/84</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Austria</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Steven Talach</b>		14. MOTHER'S MAIDEN NAME <b>Anna Slonock</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>219-12-6685</b>	
17. INFORMANT <b>SPRINGFIELD STATE HOSP., SYKESVILLE, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration Pneuonia - stasis</b> DUE TO (b) <b>CVA + Residual Paralysis</b> DUE TO (c) <b>-----</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS assoc. with cerebral arteriosclerosis with psychotic react.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>5/6/58</b> , 19 <b>48</b> to <b>5/29/67</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>5/29/67</b> , 19 <b>67</b> , and that death occurred at <b>3:45</b> A.M., from causes and on the date stated above.			
22a. SIGNATURE <b>Huell E. Connor, Jr.</b>		22b. DATE SIGNED <b>5/29/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Huell E. Connor, Jr., M.D.</b>		22d. ADDRESS <b>Springfield State Hospital, Sykesville, Maryland 21784</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>6-5-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bohemian National Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>
24. FUNERAL DIRECTOR <b>Philip E. Quach 1211 Chesaco Ave</b>		25a. REC'D BY REGISTRAR <b>JUN 6 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
06537 CERTIFICATE OF DEATH 06522

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Woodbine</u> c. LENGTH OF STAY IN 1b <u>yr.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Golden Age Sun Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u> d. STREET ADDRESS <u>Broadway Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James J. Tracey</u> First Middle Last		4. DATE OF DEATH <u>May 19 1967</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 24, 1879</u> Month Day Year
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joshua Tracey</u>		14. MOTHER'S MAIDEN NAME <u>IDA GROFF</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-05-6705</u>	
17. INFORMANT <u>John F. Tracey</u> Address <u>Lutherville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u> DUE TO (b) <u>Ch. Myocarditis</u> DUE TO (c) <u>Good Control of Sclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>2</u> <u>1</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 4, 1956</u> to <u>May 19, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 19, 1967</u> , and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>A. N. Mastin</u>		22b. DATE SIGNED <u>May 19-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. N. MASTIN</u>		22d. ADDRESS <u>Westminster, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAY 22, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>JESSEUP Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>SPARKS - MD</u>	
24. FUNERAL DIRECTOR <u>Wm Cook-Brooks TOWSON</u>		25a. REC'D BY REGISTRAR <u>21204</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1883

January 1

February 1

March 1

April 1

May 1

June 1

July 1

August 1

September 1

October 1

November 1

December 1

January 1

February 1

March 1

April 1

May 1

June 1



## MEDICAL CERTIFICATION

VR A15 (4)  
15M 4-64

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1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data collection methods, the statistical methods used for data analysis, and the experimental procedures used to test the hypotheses. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous research, and a discussion of the implications of the findings. The final part of the report is a conclusion and a list of references.

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VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06533

CERTIFICATE OF DEATH

06523

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sixesville</u>		c. LENGTH OF STAY IN lb <u>8 1/2 yr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, 18.</u> <u>3014</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield ST. Hosp.</u>				d. STREET ADDRESS <u>2436 Maryland Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Daniel Jeremiah UTZ.</u>				4. DATE OF DEATH Month Day Year <u>5 28 1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-27-44</u>	9. AGE (In years last birthday) <u>23</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BY DAY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Henry UTZ.</u>				14. MOTHER'S MAIDEN NAME <u>Deborah Ecker.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-10-0124</u>		17. INFORMANT Address <u>Springfield ST. Hosp. Records</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>334X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>2 days</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic Brain Syndrome assoc. to cerebral Arter. &amp; psychotic Rx.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-6, 1968</u> to <u>5-28, 1967</u> that (I) (we) last saw the deceased alive on <u>5-28, 1967</u> , and that death occurred at <u>7:00 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>H E Connor Jr</u>				22b. DATE SIGNED <u>5-28-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. H. E Connor.</u>				22d. ADDRESS <u>Springfield ST. Hosp</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-31-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK</u>		23d. LOCATION (City or Town) (County) (State) <u>CARROLL COUNTY MD</u>	
24. FUNERAL DIRECTOR <u>DR. Hutzler NEW WINDSOR MD</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 31 1967</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Judge</u>	

10-10-53

OFFICE OF THE DIRECTOR

10-10-53

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RECEIVED  
OCT 10 1953  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06540

CERTIFICATE OF DEATH

06524

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Airy</u>		c. LENGTH OF STAY IN 1b <u>2 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>807 S. Main Street</u>		e. STREET ADDRESS <u>807 S. Main Street</u>	
3. NAME OF DECEASED (Type or print) <u>Sophia Dorsey Glover Webb</u>		4. DATE OF DEATH <u>May 14 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 20, 1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Social Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles P. Glover</u>		14. MOTHER'S MAIDEN NAME <u>Anna Dorsey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>135-01-0262</u>	
17. INFORMANT <u>Mrs. Ruth Webb</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Gastrointestinal Hemorrhage</u> DUE TO <u>due to undetermined cause</u> (b) <u>(also) - Arteriosclerotic cardiovascular disease</u> DUE TO <u>lost</u> (c) <u>more than 5 years.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>less than 1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March, 1967</u> , to <u>May</u> , 1967, that (I) (we) last saw the deceased alive on <u>May 14 1967</u> , and that death occurred at <u>6:00 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>W.B. Culwell</u>		22b. DATE SIGNED <u>MAY 15, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>W.B. Culwell</u>		22d. ADDRESS <u>900 So. Main St. Mt. Airy, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/17/1967</u>	23c. NAME OF CEMETERY <u>Pine Grove</u>	23d. LOCATION (City or Town) (County) (State) <u>Mt. Airy, Md.</u>
24. FUNERAL DIRECTOR <u>C. M. Waltz Box 241 Sykesville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 17 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

00540

REPUBLIC OF CHINA

MINISTRY OF NATIONAL DEFENSE

1

1. NAME		2. GRADE		3. POSITION	
4. ADDRESS		5. CITY		6. PROVINCE	
7. POSTAL CODE		8. TELEPHONE		9. FAX	
10. E-MAIL		11. BIRTH DATE		12. BIRTH PLACE	
13. EDUCATION		14. OCCUPATION		15. INTERESTS	
16. ACHIEVEMENTS		17. RECOMMENDATIONS		18. REMARKS	

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06541

## CERTIFICATE OF DEATH

06525

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Parkton</u>		d. STREET ADDRESS <u>Mt. Carmel Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Co. Gen. Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Harvey Wells</u>		4. DATE OF DEATH Month <u>5</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 7, 1908</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>9</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Highway Dept. Baltimore Co., Md.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Wells</u>		14. MOTHER'S MAIDEN NAME <u>Rosa May Armacost</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-28-4123</u>	
17. INFORMANT <u>Mrs. Donald Wilhelm</u>		Address <u>Freeland, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) <u>CEREBRAL ANOXIA</u>			
DUE TO (b) <u>PULMONARY INSUFFICIENCY</u>			
DUE TO (c) <u>PULMONARY EMPHYSEMA</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>METASTATIC CARCINOMA OF LUNG + LIVER (PRIMARY - BOWEL)</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4/29</u> , 19 <u>67</u> , to <u>5/9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/9</u> , 19 <u>67</u> , and that death occurred at <u>11:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Theresa J. Krocco Jr.</u> M.D.		22b. DATE SIGNED <u>5/9/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>Burial</u>	<u>May 12, 1967</u>	<u>Mt. Carmel Cemetery</u>	<u>Parkton, Md.</u>
24. FUNERAL DIRECTOR <u>Jacob Hartenstein</u>		25. REGD. BY REGISTRAR <u>May 15 1967</u>	
ADDRESS <u>New Freedom, Pa.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE

FOR MARRIAGE INSURANCE

FOR MARRIAGE INSURANCE

FOR MARRIAGE INSURANCE

WITNESSES

WITNESSES

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